

Physicians in Family Practice 1931-67

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A SPECIALTY in family practice was established in 1969 in response to growing concern about the need for increasing the availability of comprehensive and continuous patient care. The great consideration given to the breadth and depth of residency training by those establishing this new specialty reflects the intention to improve the scope of responsibility and the quality of care provided by the traditional family physician.

Another major consideration in establishing the residency program for the specialty was to make the new "family practice" more attractive to the student whose major exposure in medical school had been to specialties rather than to general practice. An approved residency in general practice with no recognized specialty board has existed for a number of years. Only a small number of physicians have been taking advantage of this residency.

Although many educators and planners have felt that specialists in internal medicine, pediatrics, obstetrics, and gynecology would serve the functions of the family practitioners, these specialists have not replaced the losses occurring in the field of general practice, either in numbers or geographic distribution. This article documents the national numerical trends in those fields of practice of most physicians engaged in family practice in the last few decades.

In 1959 the Surgeon General's Consultant Group on Medical Education reported the trend toward specialization as it had affected the gross potential of family physicians (1). They stated that the 1957 count of physicians (doctors of medicine and doctors of osteopathy) showed that less than half of the physicians in private

practice limited themselves to specialty practice (table 1) compared with one in four in 1940 and one in six in 1931. For the 1931-57 time period, detailed information available for doctors of medicine only was used in the report to obtain physician-population ratios. Specialists in private practice per 100,000 population increased from 17.9 in 1931 to 25.5 in 1940, 36.8 in 1949, and 43.5 in 1957.

For purposes of estimating the potential number of physicians performing the functions of the family practitioner, the report (1) combined specialists who limited their practice to internal medicine and pediatrics and physicians who were in general practice or part-time specialties. Information available only for doctors of medicine in private practice from 1931 to 1957 showed that 75 percent were part of this pool of potential family physicians in 1931 compared with 67 percent in 1940, 55 percent in 1949, and 45 percent in 1957. Specialty information for the doctors of osteopathy during this period was not available. The family physician potential, based on the number in private practice per 100,000 civilian population, dropped from 94 in 1931 to 89 in 1940, 75 in 1949, and 60 in 1957 (fig. 1 and table 2).

Since the Surgeon General's report was published, a number of changes have been made in counting methods and classification systems

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for physicians (2, 3). Although the information improved, the changes affected the comparability of data published for the periods before and after 1963. Estimates and adjustments were made for several major categories in the earlier period, but comparisons between these periods for the specialties and private practice classification are difficult (2).

Interest in this grouping of physicians is still pertinent, particularly since the new specialty in family practice was formed. The data used to compare time periods from December 31, 1963, to December 31, 1967, were taken from detailed tabulations (4-7) published by the American Medical Association (AMA) and the American Osteopathic Association (AOA). The report of the Surgeon General (1) and later Public Health Service publications used similar tabulations.

The data for my article are presented in the usual Public Health Service format, with minor modifications and with definitions inherent to the tabulations used. The category of general practitioner includes those physicians who did not specify a specialty (about two-thirds of whom are in internship programs) and those specifying a part-time specialty. This grouping is consistent with the earlier general practice category in which all active physicians who did not specify a full-time specialty were assumed to be general practitioners.

In the AMA tabulations, physicians specifying a specialty practice were not necessarily trained or certified in that specialty. The American Medical Association formally recognized the family practice specialty on January 1, 1970. When the data are tabulated for 1970, it will be interesting to see how many general practitioners, pediatricians, and internists have designated family practice as their specialty.

The difficulties of trying to describe numerically the changes in the pool of physicians serving the public have been discussed frequently. Changes in the methods of applying our rapidly expanding knowledge and the productivity of physicians, as well as quality changes, cannot be measured easily. Changes in population composition and demand also are not reflected. The increasing proportions of persons in the old and very young age ranges affect the incidence of certain types of diseases that must be treated. Changing expectations for health care created by economics, education, and mobility magnify the effects of the age factor on the services sought by the public. The physician-population ratio, although an insensitive index, is still the primary means of relating the number of physicians to the population served.

The number of total active physicians increased about 12 percent from 1963 to 1967, while the gross potential of family physicians, adjusted for activity, increased only about 4

Table 1. Physicians (M.D.'s and D.O.'s) in the United States, by type of practice, midyear 1957

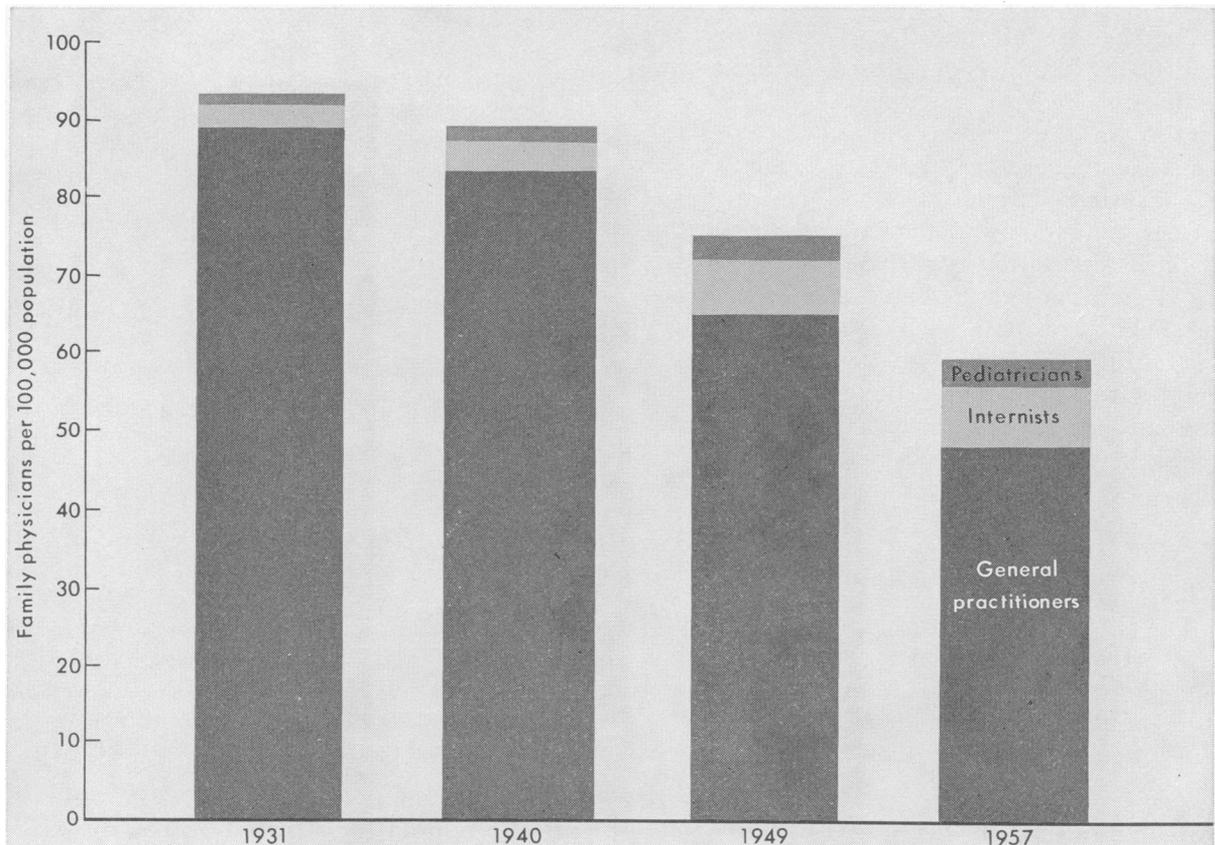
Type of practice	Doctors of medicine		Doctors of osteopathy	
	Number	Rate per 100,000 population	Number	Rate per 100,000 population
Total.....	226, 625	132. 4	13, 692	8. 0
Private practice.....	155, 827	91. 1	9, 501	5. 6
General practice and part-time specialty.....	81, 443	47. 6	8, 656	5. 1
Full-time specialty.....	74, 384	43. 5	845	. 5
Not in private practice.....	60, 137	35. 1	1, 205	. 7
Hospital service except Federal.....	36, 371	21. 2	872	. 5
Teaching, research, public health, other.....	7, 168	4. 2	321	. 2
Federal Government.....	16, 598	9. 7	12	(¹)
Retired, not in practice.....	10, 661	6. 2	² 2, 986	1. 7

¹ Less than 0.05.

² Includes 2,006 D.O.'s who did not report type of practice.

SOURCE: Reference 1.

Figure 1. Family physician (M.D.) potential per 100,000 population, midyear 1931-57



SOURCE: Reference 1.

percent (table 3). Although the ratio of total active physicians to population continued to increase in the 1963-67 period, from 140 to 150 per 100,000 population, the ratio of the gross potential for family physicians (all active in family practice specialties) remained about the same.

Gross Potential of Family Physicians

The gross potential numbers of family physicians among total active physicians, without considering the possible activities, increased from 142,901 in 1963 to 149,426 in 1967 (table 3). Despite the increased numbers, the gross potential percentage of family physicians among total active physicians dropped from 52.4 to 48.9 in the 5-year period. Most of the decrease occurred in the general practice and

unspecified physician category, from 34.4 to 29.2 percent. The proportion of specialists limited to pediatrics increased slightly from 5.2 to 5.8 percent, while the proportion in internal medicine increased from 12.8 to 13.9 percent.

The ratio of the gross potential of family physicians per 100,000 population stayed about the same for 5 years: 73.6 in 1963 and 73.4 in 1967. Specialists in internal medicine, whose ratio increased from 18.0 to 20.9 per 100,000 population, maintained the balance. (This balance does not hold for only those physicians in patient care, as explained in the next section.) The proportion of specialists in pediatrics also increased from 7.3 to 8.7 per 100,000 population. The increases in these specialties offset the decrease in the general practitioner and unspecified category from 48.3 to 43.8 per 100,000 population. The gross potential of family physicians

does not tell the whole story of access by the civilian population or of physicians' activities.

Comparisons of total active physicians are inadequate for these purposes. The figures include non-Federal physicians (M.D.'s and D.O.'s) in the United States, Puerto Rico, American Samoa, the Canal Zone, Guam, Pacific Islands, and Virgin Islands; those with addresses temporarily unknown to the American Medical Association; and Federal physicians in the United States and abroad. The corresponding population data include resident civilian and military personnel in the United States, Puerto Rico, and the outlying areas, military personnel and their dependents abroad, and civilians abroad employed by the U.S. Government (8, 9). Categories that make the data more definitive are discussed in the next section.

Type of Practice and Activity

The old AMA classifications accorded to private practice are no longer used or available. The American Medical Association changed the classification system (see following list) to reflect patient care activities.

Old classification

Private practice

Training programs:

Interns

Residents and fellows

Full-time hospital staff

Preventive medicine

Research

Medical school faculty

Administration

Laboratory medicine

Inactive, address unknown

New classification

Patient care:

Solo, partnership, group, or other practice

Hospital-based practice:

Interns

Residents and fellows

Full-time physician staff

Other professional activity:

Medical school faculty

Administration

Research

Inactive, address unknown

The categories of preventive medicine and laboratory medicine were eliminated. Physicians in these two categories were reclassified according to principal employer. Physicians in the spe-

Table 2. Family physician (M.D.) potential and ratios to population, United States, midyear 1931-57

Type of practice	1931	1940	1949	1957
Number of physicians				
Total physicians.....	156, 406	175, 163	201, 277	226, 625
Family physician potential ¹	117, 079	117, 386	110, 236	101, 973
Pediatrics ²	1, 396	2, 222	3, 787	5, 876
Internal medicine ²	3, 567	5, 892	10, 923	14, 654
General practice and part-time specialty.....	112, 116	109, 272	95, 526	81, 443
All others.....	39, 327	57, 777	91, 041	124, 652
Physicians per 100,000 civilian population				
Family physician potential.....	94	89	75	60
Pediatrics.....	1	2	3	3
Internal medicine.....	3	4	7	9
General practice and part-time specialty.....	90	83	65	48
Percent of total physicians				
Family physician potential.....	75	67	55	45
Pediatrics.....	1	1	2	3
Internal medicine.....	2	3	5	6
General practice and part-time specialty.....	72	63	48	36

¹ Includes only physicians in private practice.

² Estimated from total number of physicians limited to a specialty.

SOURCE: Reference 1.

Table 3. Gross family physician potential, United States, Puerto Rico, and outlying areas, December 31, 1963 and 1967

Specialty category	All physicians		Doctors of medicine		Doctors of osteopathy	
	1963	1967	1963	1967	1963	1967
	Number					
Total active physicians ¹	272, 500	305, 453	261, 728	294, 072	10, 772	11, 381
Gross family physician potential.....	142, 901	149, 426	133, 001	139, 131	9, 900	10, 295
General practice and unspecified.....	93, 705	89, 157	84, 052	79, 192	9, 653	9, 965
Pediatrics ²	14, 253	17, 678	14, 207	17, 614	³ 46	³ 64
Internal medicine.....	34, 943	42, 591	34, 742	42, 325	³ 201	³ 266
	Percent ⁴					
Total active physicians.....	100. 0	100. 0	100. 0	100. 0	100. 0	100. 0
Gross family physician potential.....	52. 4	48. 9	50. 8	47. 3	91. 9	90. ⁴
General practice and unspecified.....	34. 4	29. 2	32. 1	26. 9	89. 6	87. 6
Pediatrics ²	5. 2	5. 8	5. 3	6. 0	. 4	. 6
Internal medicine.....	12. 8	13. 9	13. 3	14. 4	1. 9	2. 3
	Physicians per 100,000 population ⁴					
Total population (1,000's) ⁵	194, 169	203, 708	194, 169	203, 708	194, 169	203, 708
Total active physicians.....	140. 3	149. 9	134. 8	144. 4	5. 5	5. 6
Gross family physician potential.....	73. 6	73. 4	68. 5	68. 3	5. 1	5. 0
General practice and unspecified.....	48. 3	43. 8	43. 3	38. 9	5. 0	4. 9
Pediatrics.....	7. 3	8. 7	7. 3	8. 6	(⁶)	(⁶)
Internal medicine.....	18. 0	20. 9	17. 9	20. 8	. 1	. 1

¹ Includes non-Federal physicians in the 50 States, District of Columbia, Puerto Rico, American Samoa, Canal Zone, Guam, Pacific Islands, and Virgin Islands; those with addresses temporarily unknown to the AMA; and Federal physicians in the United States and abroad.

² Includes pediatrics, pediatric allergy, and pediatric cardiology.

³ Private practice only.

⁴ Totals of percents and ratios may not add because of rounding.

⁵ Includes civilians in the United States, Puerto Rico, and outlying areas; the Armed Forces in the United States and abroad; dependents of the Armed Forces abroad; and U.S. civilians working for the U.S. Government abroad.

⁶ Less than 0.05 per 100,000 population.

SOURCE: References 4, 5, and 6.

cialty of administrative medicine were reclassified according to their secondary specialty, and those who did not report a secondary specialty were reclassified as "not recognized."

In the new classification system, physicians providing patient care are grouped by hospital and nonhospital-based practices. Hospital-based patient care is delivered by interns, residents, and fellows, and a full-time physician staff. Nonhospital-based patient care includes only non-Federal physicians in the category of solo, partnership, group, or other practice.

Nonhospital-based patient care is somewhat similar to the old private practice group but is larger and includes all physicians in patient care not otherwise classified. Besides physicians providing patient care in office settings, this category includes physicians in clinical labora-

tories or institutional settings other than hospitals, those providing patient care in industrial plants and as State and local health officers, and those in other settings. Many physicians in "other" settings are in administration or research and are not included in patient care; therefore, they are not included in the category of patient care. Descriptions of this sort are not clean-cut.

The American Osteopathic Association still uses a private practice classification. Adjustments in the AOA data have been made wherever possible to make the two systems comparable.

During the 5-year period 1963-67, the activity categories showed great change (table 4). The total number of physicians, active and inactive, increased from 289,188 to 322,045, or 11 percent;

those active in solo, partnership, group, or other practice increased from 189,267 to 200,146, or 6 percent. Of the physicians in solo, partnership, group, or other practice, those limiting themselves to a specialty practice increased from 59 to 64 percent. The number of hospital-based physicians increased from 68,341 to 85,239, or 25 percent. While the number of all physicians in patient care increased from 257,608 to 285,385 (11 percent), the number of physicians in non-patient care increased from 14,892 to 20,068 (35 percent); therefore, the fastest growth was in nonpatient care activities. The number of physicians in hospital-based patient care also increased at a fast rate.

The ratio of physicians per 100,000 population increased as follows: total physicians from 148.9 to 158.1, physicians in patient care from 132.7 to 140.1, and those in solo, partnership, group, or other practice from 97.5 to 98.3. The large increase in hospital-based physicians, from 35.2 to 41.8 per 100,000 population, should be

viewed with some reservation, since more than half of these physicians were in the Federal service. Although a large increase occurred in the non-Federal segment, part of the increase may have reflected a temporary buildup in the Federal service for the Vietnam conflict.

In 1967, the doctors of osteopathy represented about 4 percent of all active physicians, 7 percent of those in the gross family physician potential, 11 percent of those in general practice (table 3), 4 percent of all physicians in patient care, and 5 percent of those in solo, partnership, group, or other practice—actually private practice for the doctors of osteopathy. Within the category of solo, partnership, group, or other practice, they comprised 11 percent of general practitioners (table 4).

Family Practice for Civilians

The civilian population had most access to the group of family practice physicians in solo, partnership, group, or other practice (table 5).

Table 4. Physicians (M.D.'s and D.O.'s) by type of practice, United States, Puerto Rico, and outlying areas, December 31, 1963 and 1967

Type of practice	All physicians		Doctors of medicine		Doctors of osteopathy	
	1963	1967	1963	1967	1963	1967
	Number					
Total physicians.....	289, 188	322, 045	276, 475	308, 630	12, 713	13, 415
Patient care.....	257, 608	285, 385	246, 951	274, 190	10, 657	11, 195
Solo, partnership, group, or other practice ¹	189, 267	200, 146	179, 449	190, 079	9, 818	10, 067
General practice and unspecified.....	77, 427	71, 495	68, 728	62, 844	8, 699	8, 651
Limited to specialty practice.....	111, 840	128, 651	110, 721	127, 235	1, 119	1, 416
Hospital-based physicians ²	68, 341	85, 239	67, 502	84, 111	839	1, 128
Not in patient care ³	14, 892	20, 068	14, 777	19, 882	115	186
Inactive, address unknown.....	16, 688	16, 592	14, 747	14, 558	1, 941	2, 034
	Physicians per 100,000 population ⁴					
Total population (1,000's) ³	194, 169	203, 708	194, 169	203, 708	194, 169	203, 708
Total physicians.....	148. 9	158. 1	142. 4	151. 5	6. 5	6. 6
Patient care.....	132. 7	140. 1	127. 2	134. 6	5. 5	5. 5
Solo, partnership, group, or other practice ¹	97. 5	98. 3	92. 4	93. 3	5. 1	4. 9
General practice and unspecified.....	39. 9	35. 1	35. 4	30. 8	4. 5	4. 2
Limited to a specialty practice.....	57. 6	63. 2	57. 0	62. 5	. 6	. 7
Hospital-based physicians ²	35. 2	41. 8	34. 8	41. 3	. 4	. 5
Not in patient care ³	7. 7	9. 9	7. 6	9. 8	. 1	. 1
Inactive, address unknown.....	8. 6	8. 1	7. 6	7. 1	1. 0	1. 0

¹ D.O.'s in private practice only.

² Includes interns, residents, fellows, and full-time physician staff.

³ Includes medical and osteopathic school faculties and those in administration and research. Also includes 7 D.O.'s in 1963 and 34 in 1967 in miscellaneous cate-

gories that were not private practice, hospital staff, osteopathic school faculty, administration, or research.

⁴ Totals may not add because of rounding.

SOURCE: References 4, 5, and 6.

Table 5. Physicians in solo, partnership, group, or other practice, United States, Puerto Rico, and outlying areas, December 31, 1963 and 1967

Specialty category	All physicians		Doctors of medicine		Doctors of osteopathy ¹	
	1963	1967	1963	1967	1963	1967
	Number					
Physicians in solo, partnership, group, or other practice.....	189,267	200,146	179,449	190,079	9,818	10,067
Family physician potential.....	108,324	106,243	99,378	97,262	8,946	8,981
General practice and unspecified.....	77,427	71,495	68,728	62,844	8,699	8,651
Pediatrics ²	9,458	10,530	9,412	10,466	46	64
Internal medicine.....	21,439	24,218	21,238	23,952	201	266
	Percent ³					
Physicians in solo, partnership, group, or other practice.....	100.0	100.0	100.0	100.0	100.0	100.0
Family physician potential.....	57.2	53.1	55.4	51.2	91.1	89.2
General practice and unspecified.....	40.9	35.7	38.3	33.1	88.6	85.9
Pediatrics ²	5.0	5.3	5.2	5.5	.5	.6
Internal medicine.....	11.3	12.1	11.8	12.6	2.0	2.6
	Physicians per 100,000 civilian resident population ³					
Civilian resident population (1,000's) ..	190,892	199,783	190,892	199,783	190,892	199,783
Physicians in solo, partnership, group, or other practice.....	99.2	100.2	94.0	95.1	5.1	5.0
Family physician potential.....	56.8	53.2	52.1	48.7	4.7	4.5
General practice and unspecified.....	40.6	35.8	36.0	31.4	4.6	4.3
Pediatrics ²	5.0	5.3	4.9	5.2	(⁴)	(⁴)
Internal medicine.....	11.2	12.1	11.1	12.0	.1	.1

¹ D.O.'s in private practice only.

² Includes pediatrics, pediatric allergy, and pediatric cardiology.

³ Totals may not add because of rounding.

⁴ Less than 0.05 per 100,000 population.

SOURCE: References 4, 5, and 6.

Other physicians providing patient care were the hospital-based interns, residents, and fellows, and full-time hospital staff. The hospital staff generally are not considered to be available as family physicians.

Nonhospital-based physicians in solo, partnership, group, or other practice increased from 189,267 in 1963 to 200,146 in 1967, slightly increasing the physician-population ratio from 99.2 to 100.2 per 100,000 civilian resident population. The physician potential in family practice, however, declined. The total number decreased from 108,324 in 1963 to 106,243 in 1967, and the physician-population ratio, from 56.8 to 53.2 per 100,000 civilian resident population. This decrease reinforces current discussions concerning national shortages of family or primary physicians although it does not reflect the many variations in numbers and characteristics of physicians in geographic areas.

The component changes demonstrate that the

increase in the number of specialists in pediatrics and internal medicine was not enough to balance the decrease in the general practitioner and unspecified category. (The number of physicians in unspecified activities was only about 100 each year. The following references to general practice include the unspecified although they may not be mentioned.) The decrease of 5,932 general practitioners (77,427 to 71,495) for the 5-year period was not offset by the increase of 1,072 limited-specialty pediatricians and 2,779 limited-specialty internists. In ratios of physicians per 100,000 civilian residents, general practitioners decreased from 40.6 to 35.8, pediatricians increased from 5.0 to 5.3, and internists increased from 11.2 to 12.1 (fig. 2).

Osteopathic physicians represented such a small segment of the national total of physicians that their main effect was only as general practitioners. About 12 percent of general practi-

tioners in nonhospital-based patient care were doctors of osteopathy; the percentage varied significantly in certain States and counties. Within the osteopathic profession, the proportion of specialists in pediatrics increased from 0.5 to 0.6 percent of all doctors of osteopathy in private practice, and the proportion of internists increased from 2.0 to 2.6 percent.

Obstetrics and Gynecology

Although general practitioners historically have functioned as all-round family physicians, many of the more technical and sophisticated applications of our vast medical knowledge have been referred to specialists as they have become available. Many pediatricians and internists provide the more comprehensive functions of the family physician, according to the age of the patient. Sample surveying by the Health Information Foundation and the National Opinion Research Foundation in 1963 indicated the primary specialty of doctors of medicine used as regular sources of care. Fifty-six percent of the sampled population obtained care from general practitioners, 12 percent from general surgeons, 10 percent from internists, 8 percent from pediatricians, 7 percent from obstetrician-gynecologists, and 7 percent from other specialists (10).

A great, continuing need exists for obstetrician-gynecologist care, particularly; the limited numbers of specialists in this field have not been able to meet the demand for these specialized services. General practitioners and some internists still treat a number of such patients in order to cover the shortage.

Despite comparability difficulties, the data indicate that both the number and percentage of specialists limited to obstetrics and gynecology in the total of all active physicians have increased steadily in the last few decades. These increases, from less than 1 percent of total active doctors of medicine in 1931 to almost 6 percent of all active physicians in 1967, show the growing contribution to one segment of family practice.

The Surgeon General's report (1) did not include obstetrician-gynecologists in the discussion of family practice. Midyear data concerning all active doctors of medicine who

limited their practice to a specialty (11), 1931 through 1962, showed less than 1 percent in 1931 and almost 5 percent in 1962: there were 1,418 in 1931, 2,551 in 1940, 5,074 in 1949, 8,147 in 1957, and 11,680 in 1962. Obstetrician-gynecologists represented about 6 percent of all doctors of medicine who limited their practice to a specialty in 1931, and about 9 percent in 1962. This increase indicates that the growth of the specialty more than matched the growth of all specialties during the 30-year period.

During 1963-67, the number of specialists limited to obstetrics and gynecology increased from 15,789 to 18,044, increasing the physician-population ratio from 8.1 to 8.8 per 100,000 population (table 6). The number of physicians serving the civilian resident population in solo, partnership, group, or other practice, increased from 11,874 to 13,205 and their ratio from 6.2 to 6.6. With a decrease in potential family practice

Figure 2. Family physician (M.D. and D.O.) potential per 100,000 population, 1963 and 1967 (based on table 5)

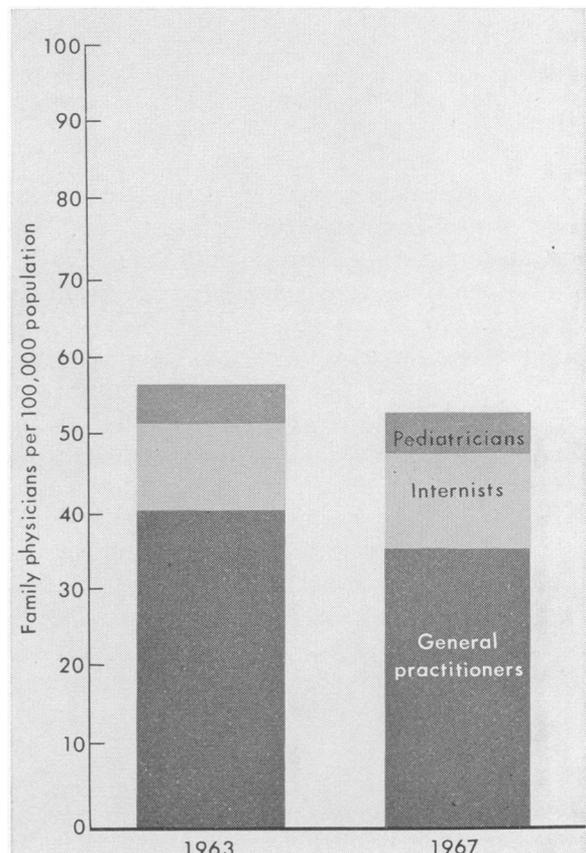


Table 6. Specialists in obstetrics and gynecology, United States, Puerto Rico, and outlying areas, December 31, 1963 and 1967

Specialty category	Total active physicians		Physicians in solo, partnership, group, or other practice	
	1963	1967	1963	1967
	Number			
Total active physicians	272, 500	305, 453	189, 267	200, 146
Obstetrics-gynecology specialists ¹	15, 789	18, 044	11, 874	13, 205
M.D.'s	15, 720	17, 964	11, 805	13, 125
D.O.'s ²	69	80	69	80
	Percent ³			
Total active physicians	100. 0	100. 0	100. 0	100. 0
Obstetrics-gynecology specialists	5. 8	5. 9	6. 3	6. 6
M.D.'s	5. 8	5. 9	6. 2	6. 6
D.O.'s ²	(⁴)	(⁴)	(⁴)	(⁴)
	Physicians per 100,000 population ⁵			
Population (1,000's) ⁵	194, 169	203, 708	190, 892	199, 783
Obstetrics-gynecology specialists	8. 1	8. 8	6. 2	6. 6
M.D.'s	8. 1	8. 8	6. 2	6. 6
D.O.'s ²	(⁴)	(⁴)	(⁴)	(⁴)

¹ Physicians limiting their practice to a specialty.

² D.O.'s in private practice only.

³ Totals may not add because of rounding.

⁴ Less than 0.05.

⁵ Ratios based on total population for total active

physicians, civilian resident population for physicians in obstetrics and gynecology in solo, partnership, group, or other practice.

SOURCE: References 4, 5, and 6.

in solo, partnership, group, or other practice from 56.8 to 53.2 per 100,000 civilian resident population, the slight increase in the ratio of obstetrician-gynecologists did not have much impact on family practice.

Summary

A continuing increase in the total number of physicians in the United States has resulted in a rising physician-population ratio in the last few decades. Physician potential in family practice, on the other hand, consistently has shown a reverse trend, both in numbers and in relation to population. The pool of potential family physicians, defined as general practitioners, internists, and pediatricians, in solo, partnership, group, or other practice, decreased from 56.8 in 1963 to 53.2 in 1967 per 100,000 civilian resident population. Increases in the internal medicine and pediatrics categories were not enough to make up for the decrease in the general practice category. The slight increases

in the number of obstetrician-gynecologists did not have much impact on the decreasing trend in family practice.

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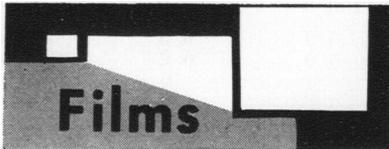
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Tearsheet Requests

Information Office, Division of Physician Manpower, National Institutes of Health, Bethesda, Md. 20014



The Story of Rocky Mountain Spotted Fever. Order No. M-1715-X. Motion picture, 16 mm., color, sound, 29 minutes, 1969.

SUMMARY: Explains the efforts to develop a vaccine and to control the tick vector with appropriate tribute to those scientists who lost their lives while working toward these goals. The long battle against Rocky Mountain spotted fever, a serious and once highly fatal disease, was filmed near the Rocky Mountain Laboratory of the National Institute of Allergy and Infectious Diseases where much of the pioneer research was done.

Life History of the Rocky Mountain Wood Tick. Order No. M-1716-X. Motion picture, 16 mm., color, sound, 18 minutes, 1969.

SUMMARY: Details the 2-year life-span of the major vector of Rocky Mountain spotted fever in the West. Closeup filming of the tick and his habits alternate with color shots capturing the beauty of the Montana landscape.

AUDIENCE: Medical and other health-related students as well as secondary school science and biology classes. Groups interested in outdoors or in disease in nature transmissible to man will also enjoy these films.

AVAILABLE: One or both films on free short-term loan from the National Medical Audiovisual Center

(Annex), Station K, Atlanta, Ga. 30324. Purchase from General Services Administration, National Archives and Records Service, Washington, D.C. 20409. Attention: Government Film Sales.

The National Medical Audiovisual Center has sponsored and produced a series of films to provide the medical viewer with the divergent points of view of experts representing their specialty fields. The series, based on contemporary medical thinking, presents questions for which the logic of medical science alone fails to provide clear, unequivocal answers.

AUDIENCE: For professional medical audiences. Cleared for television.

Indications for a Therapeutic Abortion. Order No. T-1720. Motion picture, 16 mm. (TFR), black and white, sound, 31 minutes, 1969.

SUMMARY: Moderator: The Honorable Richard Lamm, attorney and State legislator from Colorado. Panelists: Alan F. Guttmacher, M.D., president, Planned Parenthood-World Population, and Frank J. Ayd, Jr., M.D., editor, The Medical-Moral Newsletter.

Representative Lamm presents statistics regarding abortion in Colorado since liberalization of the State law. Dr. Ayd feels that a fetus is a human being from the moment of conception and that abortion is murder. He states that many women suffer guilt feelings after termination of pregnancy, and he is opposed to liberalization of the laws. Dr. Guttmacher believes the fertilized egg is only a potential human being until birth, that abortion can con-

tribute to the happiness of the woman involved, and that the laws should be made more liberal.

Smallpox Vaccination—Should Our Policy Be Changed? Order No. T-1678. Motion picture, 16 mm. (TFR), black and white, sound, 28½ minutes 1969.

SUMMARY: Moderator: Paul Wehrle, M.D., professor and chairman, department of pediatrics, University of Southern California School of Medicine. Panelists: John Neff, M.D., assistant professor of pediatrics, Johns Hopkins University School of Medicine, and Samuel Katz, M.D., professor and chairman, department of pediatrics, Duke University School of Medicine.

Dr. Neff contends that our present vaccination policy for American children should be changed, since far more children die or suffer from vaccination complications than from smallpox. Dr. Katz contends that our current freedom from smallpox is totally dependent on the continued use of the vaccine.

These films are available on free short-term loan from the National Medical Audiovisual Center (Annex), Station K, Atlanta, Ga. 30324. Order films by title and number. Films should be requested at least 2 weeks before the preferred showing date; if possible, two alternate showing dates should be given. For purchase, order films by title and number from General Services Administration, National Archives and Records Service, Washington, D.C. 20209. Attn: Government Film Sales.